Berkeley Unified School District
Cash in Lieu Form

In order to receive cash in lieu, all employees will be required to submit proof of group health coverage which provides minimum value health insurance as established by the Federal Patient Protection Affordable Care Act (ACA) and is maintained by an employer or employee organization.

Employees working under 30 hours per week (less than .80 FTE) will qualify with proof of any health policy which meets the ACA guidelines for minimum value health coverage. Employees working 30 hours or more per week (.80 FTE or greater) will be required to submit proof of qualifying group health coverage that provides minimum value coverage as defined by ACA, and is maintained by an employer or employee organization.

Coverage, such as (but not limited to) Tricare, Medicare, Medi-Cal, and Covered California, are **not** eligible to receive cash in lieu of other health coverage, even if the coverage provides minimum value for **Employees working 30 hours or more per week.**

**Please complete the form below, attach relevant verifying documentation, and submit it to the Benefits Office to begin and/or continue cash-in-lieu. **

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I certify that I am covered by another qualifying group health plan that conforms to the Affordable Care Act's (ACA's) minimum value standards. I certify that I will maintain coverage in a qualifying group health plan on an ongoing basis and agree to notify the District Risk Management/Benefits within 30 days if I lose/change coverage.

Name of Employer Providing Qualified Group Coverage:	Other Qualifying Group Coverage though (name & relationship):
	☐ Spouse ☐ Domestic Partner ☐ Parent ☐ Other_____ First Name: Last Name:

I have attached documentation of such coverage and further understand that participation is contingent upon annual verification of this coverage.

I waive, freely, knowingly and voluntarily, any and all claims and entitlement to health insurance coverage or contributions by, from, or through the District. I also release and hold harmless the District, its agents, officers and employees, from and against any and all claims, demands, and liability of costs and expenses that may in whole or in part, arise from or be based upon the lack of such coverage and/or contributions.

I understand a copy of this document will be placed in my official personnel file.

Current FTE:_________ **Social Security Number**: _____________________ **Union:** ____________

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Name of Employee **(print)** **Signature of Employee** **(date)**